WOUNDS IN HOME CARE
Providing Great Care and Still Making a Profit

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Are you having trouble putting all the pieces together?

Steps to Accurate Wound Assessment and Documentation to Minimize Loss
Goals

- 1. Understand appropriate classification of wounds to assure accurate OASIS documentation and coding
- 2. Understand Medicare Benefits Policy as it relates to wound care.
- 3. Understand appropriate documentation to prevent Medicare denials and maximize reimbursement
- 4. Understand Importance of Staff Education in using appropriate products to reduce nursing visits and increasing healing rates to maximize profit

OASIS

- Outcome and Assessment Information Set
- Medicare guidelines for Home Health assessments
- Assessments are completed on Start of Care, Resumption of Care, Recert and Discharge
- Used to determine progression or regression of patient status (outcomes)
- Results are tracked nationally (surgical wounds)
- Questions 1300-1350 track wounds
3 Categories of wounds

- Pressure Ulcers
- Stasis Ulcers
- Surgical Wounds

- Incorrect classification will impact reimbursement and outcomes
- Importance of staff (field and office) understanding proper documentation and coding

OASIS Pressure Ulcers M1300-1324

- MO 1300-1302 Pressure Ulcer Assessment: Was the patient being assessed for risk and was the patient at risk for Pressure Ulcers
- All agencies should be using an assessment tool (Braden, Norton)
- Institute standard interventions for those at risk.
Pressure Ulcer Interventions

- Support Surfaces: Group 1 support surfaces for patients a risk. Patients with current ulcers may qualify for a Group II support surface
- Wheel Chair patients should be evaluated for a seat cushion
- Moist wound healing with appropriate dressing
- Teach pressure redistribution and repositioning
- Address nutritional deficits
- Address urinary and fecal incontinence
- Order Physical Therapy for mobility issues

OASIS Pressure Ulcers M1306

- M1306 Does the patient have at least one UNHEALED Pressure Ulcer at Stage II or higher?
- Educate the staff that this includes healed stage 3 and 4 (these are never back staged... once a stage 3 or 4 always a stage 3 or 4)
**Stage 2 Pressure ulcers**

- Partial thickness, superficial ulcers, involves epidermis and/or dermis.
- If any slough is present in the wound bed, it is a stage 3.
- A blister over a bony prominence is a stage 2. (separation of the epidermis from the dermis)

**Stage 2 in ALFs**

- Be knowledgeable about the regulations in ALFs
- Facilities are allowed to have patients with stage 2 pressure ulcers but they must show improvement in 30 days.
- Community liaisons and field staff need to know these regulations
- Flag any ALF patients with stage 2 and recheck in 30 days
Stage 3 Pressure Ulcers

- Stage 3: Full thickness ulcers into the subcutaneous tissue but not involving fascia, muscle or bone. If there is slough in the wound bed it is at least a stage 3. If undermining is present it is at least a stage 3. NEVER BACK STAGE stage 3 or 4 P.U.

Stage 4 Pressure Ulcer

- Stage 4: Full thickness, tissue necrosis, damage to underlying structures (fascia, muscle, tendon, bone) Undermining and tunneling are often present.
ALFs and Stage 3-4

• ALF regulations do not allow residents to stay in the facility with stage 3-4 pressure ulcers
• Your agency will need to determine if you will accept these patients
• Community liaisons and field staff need guidelines for accepting or not accepting.

Rehab Documentation

• Rehab facilities commonly back stage pressure ulcers if patients will be returning to an ALF.
• This will allow the patient to return to a facility that has a “Healing Stage 3-4” and has been restaged as a stage 2.
• For the HHA purposes, you should document the original stage for which you have support documentation. (potential for higher reimbursement)
1308 Unstageable Pressure Ulcers

- d. 1 Unstageable: Known or likely but unstageable due to non removable dressing or device
- d. 2 Unstageable: Known or likely but unstageable due to coverage of wound bed by slough and/or eschar
- d. 3 Unstageable: Suspected deep tissue injury in evolution *****

New Category Deep Tissue Injury

Local area of purple or maroon discolored or intact skin or a blood filled blister due to pressure and/or shear damage of underlying soft tissue. Prior to discoloration, the tissue may be painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue
Deep Tissue Injury

- Protect your agency with documentation
- Nurse should notify the physician and explain this may get worse
- Nurse should inform the patient and family that this may get worse
- This will prevent accusations of poor care if and when the area opens into a stage 3 or 4 ulceration

M1320 Status of healing
Stage 2 Pressure Ulcers

- Stage 2: if present is always considered non healing.
- Reason: Stage 2 is disruption of epidermis and dermis only and heals by re-epithelialization and not by granulation and contraction as stage 3-4. Therefore the only response, if present, is non healing.
- Once the stage 2 has epithelialized it is no longer considered a pressure ulcer.
M1320 Status
Statue of Healing per WOCN guidelines
Use only for stage 3 and stage 4 pressure ulcers

-- 0-Newly epithelialized (list a healed stage 3-4 as this no matter how long it has been healed)
-- 1-Fully granulating: wound bed has granulation tissue up to the level of the wound with no necrotic tissue.
-- 2-Early/partial granulation: > 25% granulation tissue OR <25% necrotic tissue, no signs of infection, no undermining or tunneling
-- 3-Not Healing: < 25% granulation tissue OR > 25% necrotic tissue OR signs of infection, calloused or rolled edges OR undermining or tunneling OR persistent failure to improve despite appropriate treatment.

M 1322 Stage I Pressure ulcers

• Areas of non-blanchable erythema or darker pigmented area an a person of color.
• Indicates tissue ischemia and will progress rapidly if pressure not relieved.
• MO 1322 Current Number of Stage 1 Pressure ulcers.
Coding Pressure Ulcers

• Requires 2 codes.
• First code must identify the location of the pressure ulcer.
• Second must identify the stage of the pressure ulcer.
• If there are more than 2 pressure ulcers make sure that the stage that requires the most care is listed first.

Can We Avoid Pressure Ulcers?

“The Dreaded Unavoidable Event”

• Not all pressure ulcers are avoidable in Home Care (we are not there 24-7)
• Make sure an assessment was performed and appropriate interventions initiated.
• If patients and/or caregivers are non-compliant, document specifics and re-educate.
• Perform wound assessments weekly and document decline (contact MD, change wound care, etc.)
Stasis Ulcers M1330

- **M1330 Does the patient have a Stasis Ulcer**
  - Do not list arterial ulcers
  - Venous ulcers are usually located on the gaiter area of the leg
  - Irregular borders with moderate exudate
  - Often have slough in the wound bed
  - Surrounding skin discolored (brown staining called hemosiderosis) edema may be present
  - If treated with a skin graft, it remains a venous ulcer not a surgical wound

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Stasis ulcers

![Stasis ulcer images]
# Stasis Ulcers M1334

M1334 Status of Most Problematic (Observable) Stasis Ulcer

- **0-Newly Epithelialized**: New skin has covered the ulcer and there may be scar formation (Never choose this on SOC for a healed ulcer site)
- **1-Fully granulating**: Granulation to the level of the skin, no infection, no slough
- **2-Early/Partial granulation**: < 25% slough or >25% granulation tissue in wound bed, no infection, wound edges open
- **3-Non-healing**: > 25% slough or <25% granulation tissue OR presence of infection OR hyperkeratotic edges OR clean but non granulating wound bed (smooth appearance) OR Persistent failure to improve despite appropriate wound management.

## Stasis Ulcers M1334 cont.

- Generally easy to heal with proper compression
- If mistakenly identified as another type of ulcer (i.e. arterial or neuropathic) will affect outcomes and possible reimbursement
- Educate your nursing staff to identify appropriately (WOCN has educational tools on their website)
Interventions for Venous Ulcers

- Appropriate moist healing
- Compression, compression, compression
- Leg elevation
- Monitor for signs of infection
- Fluid management
- Appropriate use of diuretics
- Physical therapy evaluation for lower extremity exercises

Coding Venous Ulcers

- If visible varicose veins are present, use code 454.0
- **No** visible varicose veins, use 459.81 (venous insufficiency, unspecified) followed by the appropriate 5-digit ulcer code (707.1x) to describe its placement on the lower limb.
Surgical Wounds

- Primary intention: Wound edges are held together by sutures, staples, steristrips or skin glue

- Secondary intention: Wound is left open or opens up and healing occurs by development of new granulation tissue from the inside of the wound.

Surgical Wounds M1340

- M1340 Does the patient have a Surgical Wound?

  - Result of a recent surgical intervention i.e. ortho pin sites, debrided graft sites (not debridement of other wounds), wounds with drains, incisions with staples or sutures, incisions with scabbed or crusted areas, abscesses treated by surgical excision, biopsy sites.

  - EXCLUDE: PICC lines, site ending in “otomy” or “ostomy”, recent surgical wounds fully healed, abscess treated by I & D, pressure ulcers treated by debridement, trauma wounds treated by simple suturing, Cardiac cath site, puncture sites, cataract surgery or GYN surgery via vaginal approach.
Status of Most Problematic Surgical Wounds M1342

- M1342 Status of the Most Problematic (Primary Intention) Surgical Wound, only 2 choices

- Healing status
  - 0-Newly Epithelialized: Incision is at least 3 days old with no separation at incision line and no drainage (SOC). No surgical wound remains if site is newly epithelialized for 30 days
  - 3-Non-Healing: infection present OR incisional separation OR incisional necrosis OR drainage noted

Examples of Primary Intention

Well approximated and no drainage. Greater than 3 days newly epithelialized
Examples of Primary Intention

Non Healing due to erythema and induration. Possible infection

Non healing due to wound separation or drainage present

Surgical Wound M1342

• Healing Status: Secondary intention
  – 0- Newly Epithelialized: New skin covering the wound, no open areas or at DC has been epithelialized for at least 30 days at which time it is usually described as a scar
  – 1-Fully Granulating: Wound bed filled with granulation tissue to the level of the surrounding skin No dead space (undermining or sinus tracts) no avascular tissue (eschar or slough)
  – 2-Early Partial Granulation: > 25% of the wound bed is covered with granulation tissue, there is < 25% avascular tissue (slough or eschar). no signs or symptoms of infection, wound edges are open
  – 3-Non Healing: Wound with > 25% avascular tissue, Signs and symptoms of infection OR Clean but non granulating wound bed OR closed or hyperkeratotic wound edges OR persistent failure to improved despite appropriate management OR undermining or tunneling
Secondary Intention Surgical Wounds (dehisced)

Interventions for Surgical Wounds

- If appropriate, teach patient or CG to perform wound care (document return demonstration)
- Appropriate wound dressing
- Teach signs and symptoms of infection and infection control in the home (document what you specifically taught)
- If removal of staples or sutures to be performed in home, monitor for signs of dehiscence.
Coding Surgical Wounds

• Surgical wounds that are healing normally are not coded separately.
• Points are captured by answering M1340 and 1342. (Surgical wound and Status of site)
• Surgical wounds are only coded if not healing due to infection, separation of the wound edges or incisional necrosis.

M1350 Wounds or Lesions

• This will allow you to include any wounds or lesions not captured in prior questions THAT ARE RECEIVING AN INTERVENTION by the home health agency.
• This will include any wound that does not fall into the Pressure Ulcer, Stasis Ulcer or Surgical Wound category i.e. Arterial Ulcers, Skin Tears, Traumatic Wounds, Neuropathic Ulcers, Cellulitis, Edema, etc.
Diabetic Ulcers

- Often classified incorrectly as pressure ulcers.
- Patient with diabetes, neuropathy and ulcerations on the feet have diabetic ulcers
- Foot deformities are often present
- Test feet for sensory loss
- Remember to add diabetic foot teaching (Process measure for home care)

Intervention for Diabetic Ulcers

- Debridement of callouses by physician
- Glucose control and diabetic teaching
- Diabetic foot care teaching
- Appropriate offloading for plantar ulcers
- Assess for diabetic footwear and insoles (most diabetics on Medicare qualify for one pair of shoes yearly)
- Appropriate wound care
- Routine follow up with MD or podiatrist
Diabetic Ulcers

Related to foot deformities, pressure areas and sensory loss.

Coding Diabetic Ulcers

- The relationship between diabetes and the ulcer must be established by the physician to coorelate to diabetes with PVD, PAD or neuropathy. i.e. Diabetic arterial ulcer or neuropathic ulcer caused by diabetes. After the relationship between diabetes and the ulcer is established the coding rules for diabetes, with manifestations, need to be followed. Coding may require 3 codes.
Skin Tears
The Bane of Home Health

• Are you categorizing the type of skin tear and documenting partial or full thickness skin loss?
• Are you coding incorrectly and upcoding superficial wounds as trauma wounds?
• Is the treatment of this superficial wound a skill?
• What products can I use that are not daily?

Categorize Skin Tears
The Payne-Martin system provides classifications by degree of severity. It has three categories and two sub-categories:
• Category I: Skin tear without loss of tissue. The epidermal flap either completely covers the dermis or covers the dermis to within 1mm of the wound margin
  • Ia: Linear type
    - Ib: Flap type (flap is able to be replaced almost covering the wound)
Category 1 Skin Tear

Linear skin tears or salvageable flap

Payne Martin cont.

- Category II: Skin tears with partial tissue loss
  - IIa: Scant tissue loss (25% or less)
  - IIb: Moderate to large loss of tissue (more than 25% loss of the epidermal flap)
- Category III: Skin tears with complete tissue loss. (may be full thickness)
Category 2 Skin Tears

Partial flap loss with partial thickness wound

Category 3 Skin Tear

Full flap loss or full thickness injury
Treating Minor Wounds

- Wounds that are considered “unskilled” or wounds that are simple too small to warrant home care are a dilemma.
  - Assess if patient has another medical issue that can be added to the POC
  - Teach and train patient or caregiver to do wound care. (this is a skill)
  - Use products that are not daily. Your agency should have a formulary. Foam borders, acrylic dressings, hyrdogel sheets.
  - Instruct on maintaining healthy skin, prevention and first aid (this is a skill) Put together a patient handout for education.
  - Consider PT evaluation if injury is related to a fall
  - Document potential for complications related to specific medical conditions.

Coding Skin Tears

- Category 1 skin tears should be coded as superficial injuries and not trauma wounds.
- Category 2 skin tears can be either superficial injuries or trauma wounds, depending on complicating factors such as the presence of an underlying disease that may complicate healing, like diabetes, delayed healing, the presence of a foreign body or infection
Coding Skin Tears cont.

- Category 3 skin tears can be coded as trauma wounds because the flap is missing and the wound bed is exposed.
- Avoid coding a minor skin tear in M1020 (primary diagnosis) because it is a red flag to place a non-skilled service as a primary diagnosis.

Reducing Nursing Visits

- Use products that promote moist wound healing and do not need to be changed daily.
- Teach and train patient or caregiver when appropriate.
- Reassess every 2 weeks and if no improvement consider changing products.
- Stalled wounds may need cultures or mechanical debridement.
Reducing Nursing Visits cont.

• Work with local physicians to use your formulary (no more daily wound care)
• Educate your community liaisons on your formulary and guidelines
• Patients with slow or non healing lower extremity wounds may need a vascular consult.
• Assess patient for any comorbidities that may delay healing (treat the WHOLE patient, not just the HOLE in the patient)

Medicare Benefits Policy Manual Chapter 7

• Know the regulations for Home Care
• Educate your staff to know what constitutes a SKILL for home care
• Know homebound status
• If in doubt, go back and check the regulations
40.1.1 - General Principles Governing Reasonable and Necessary Skilled Nursing Care

- A skilled nursing service is a service that must be provided by a registered nurse or a licensed practical (vocational) nurse under the supervision of a registered nurse to be safe and effective. In determining whether a service requires the skills of a nurse, the reviewer considers both the inherent complexity of the service, the condition of the patient and accepted standards of medical and nursing practice.

40.1.2.8 -Wound Care

- Care of wounds, (including, but not limited to, ulcers, burns, pressure sores, open surgical sites, fistulas, tube sites, and tumor erosion sites) when the skills of a licensed nurse are needed to provide safely and effectively the services necessary to treat the illness or injury, is considered to be a skilled nursing service. For skilled nursing care to be reasonable and necessary to treat a wound, the size, depth, nature of drainage (color, odor, consistency, and quantity), and condition and appearance of the skin surrounding the wound must be documented in the clinical findings so that an assessment of the need for skilled nursing care can be made.
40.1.2.8 - Wound Care cont.

- Coverage or denial of skilled nursing visits for wound care may not be based solely on the stage classification of the wound, but rather must be based on all of the documented clinical findings. Moreover, the plan of care must contain the specific instructions for the treatment of the wound. Where the physician has ordered appropriate active treatment (e.g. sterile or complex dressings, administration of prescription medications, etc.)
- A list or wound types and example are in the Medicare Benefits Policy Manual

ADR’s and RAC’s
How to prevent reimbursement loss

- Review your company’s Coding for wounds (are you using correct coding or upcoding)
- Choose a good wound assessment tool
- Flag the frequent flyer patients (ALF’s and ILF’s)
- Educate your staff on proper documentation (are they showing a skill at each visit)
- Prompt intervention for wounds that show no progress

Importance of Documentation

- Documentation of all wounds should be done weekly
- It is needed for reimbursement
- Shows wound progression or regression
- Include any potential for complications and comorbidities delaying healing
- Contact the MD and Wound Nurse when warranted
- If it wasn’t charted, it wasn’t done
Photographs

• Adapt a company policy or guideline
• Permission needed from the patient (can be added to your service agreement)
• If being attached to chart, need proper documentation in photo (patient initials, MR number, date and wound location)
• Secure site for transmission
• Assists with proper coding and consults
• Able to see progression or regression and act promptly

Last but most importantly

• Legal issues
  Don’t think you can rely on memory in the event of a law suit or court case. Protect yourself and the company with thorough documentation. It only takes a few minutes and may save you future grief.
Resources

- AHCA Aspen State Regulation Set for Assisted Living Facilities
- Bates Jensen Wound Assessment Tool (copyright Barbara Bates Jensen 2001)
- Braden Risk Assessment Scale (copyright Barbara Braden and Nancy Bergstrom 1988)
- CMS Q and A
- Medicare Benefit Policy Manual Chapter 7- Home Health Services
- National Pressure Ulcer Advisory Panel  www.npuap.org
- OASIS-C Training Manual
- Payne-Martin Classification System for Skin Tears (1990)
- WOCN  www.wocn.org
- Yahoo images

Questions